

**Department of Insurance**  
**MEDICAID PROMPT**  
**PAYMENT COMPLIANCE**

**Facilitating Complaints**

**Helping to Improve Medicaid Managed Care**

❖ **WHO WE ARE**

❖ **WHAT WE DO**

❖ **WHAT WE NEED  
FROM YOU**

Medicaid Prompt Payment Compliance (MPPC) at the Department of Insurance (DOI) was created on April 15, 2013, to facilitate complaints between health care/service providers and the Managed Care Organizations (MCOs). The MCOs are contracted through the Department for Medicaid Services (DMS) to manage the health care benefits for Medicaid members in Kentucky. One main function of MPPC is the facilitation of prompt payment and any willing provider complaints as governed by the Kentucky Revised Statutes (KRS) and the Kentucky Administrative Regulations (KAR).

MPPC has resolved approximately 2,900 complaints including over 38,000 claim lines of dispute. These efforts have helped to recover over \$1.5 million in claims plus interest for a total which exceeds \$1.6 million for the health care/service providers (April 15, 2013 thru June 30, 2014). On average, approximately 750 complaints are active daily. The complaints are assigned by Medicaid region and handled by a team member responsible for that particular region.

MPPC has attempted to streamline and standardize the complaint process by creating one standard complaint form which is a writable pdf form that can be accessed and downloaded from our website. Once downloaded, input the necessary information, print the form and submit by fax or mail. Complaints are to be filed per Medicaid member per billing provider. When submitting a complaint for multiple claims and/or additional dates of service on the same Medicaid member, make sure you complete a separate **DESCRIPTION OF CLAIM AND VERIFICATION OF UNTIMELY PAYMENT** for each claim number. This process simplifies the ability for the MCOs to review and respond to the complaint. The complaint process is transparent, all information exchanged is shared between the two parties.

MPPC encourages you to familiarize yourself with the billing requirements and grievance/appeals procedures of each of the MCOs. Many times, issues can be resolved by contacting the MCO Provider Relations Department. This booklet has been prepared to provide information to you regarding our complaint process. Should you have any questions, please feel free to contact us. Our contact information is located at the end of this publication.

## **What are some of the reasons to file a complaint with MPPC?**

- ? Did the MCO fail to pay, deny or contest the clean claim within 30 days of the submission of the clean claim as required in KRS 304.17A-702?
  
- ? Did the MCO fail to acknowledge the receipt of a claim within the time frame as required or fail to notify you at the time of acknowledgement of receipt of the claim of any errors or missing information in the billing instrument as required in KRS 304.17A-704?
  
- ? Did the MCO fail to follow the procedures for claim overpayments, recoupments and/or dispute resolutions as required in KRS 304.17A-714?
  
- ? Did the MCO fail to pay interest as applicable in accordance with KRS 304.17A-730?
  
- ? Did the MCO discriminate against a provider who is located in a geographic coverage area and who is willing to meet the terms and conditions for participation established by the MCO and DMS as prescribed in KRS 304.17A-270 (any willing provider)?
  
- ? Did the MCO fail to follow the insurance statutes found in KRS 304.17A-700 thru 730?

## **Where do I go with my complaint(s)?**

- ? Did the MCO fail to pay, deny or contest the clean claim within 30 days of the submission of the clean claim as required in KRS 304.17A-702?**
- ✓ Contact or file complaint with MPPC.
- ? Did the MCO fail to acknowledge the receipt of a claim within the time frame as required; or fail to notify you at the time of acknowledgement of receipt of the claim of any errors or missing information in the billing instruments as required in KRS 304.17A-704?**
- ✓ Contact or file complaint with MPPC.
- ? Were services denied due to medical necessity or denial of a prior authorization based on medical necessity? If so, please:**
- ✓ Review the provider manual for guidance on how to file a member appeal and for the timelines required to be met in order for the appeal to be timely; and/or
  - ✓ Contact the MCO's provider relations representative; and/or
  - ✓ Contact the Department for Medicaid Services; and/or
  - ✓ Contact or file complaint with MPPC.
- ? Did you receive a denial for non-medical necessity issue(s), such as improper coding, timely filing, front end rejection, member not eligible, incorrect or missing information, no prior authorization, non-participating provider status or something other than a medical necessity issue? If so, please:**
- ✓ Review the provider manual for guidance on how to file a grievance, request for reconsideration or dispute; and/or
  - ✓ Contact the MCO's provider relations representative; and/or
  - ✓ Contact or file complaint with MPPC.
- ? Is your complaint related to a credentialing issue? If so, please:**
- ✓ Contact the MCO's provider relations representative; and/or
  - ✓ Contact Provider Relations at the Department for Medicaid Services; and/or
  - ✓ Contact or file complaint with MPPC.

## **What is the complaint process and how long does it take?**

- Every complaint must be submitted in writing using the MPPC Complaint Form
  - KENTUCKY DEPARTMENT OF INSURANCE—MEDICAID PROMPT PAYMENT COMPLAINT FORM (revision date found in lower left corner of form).
- Complaints are filed per Medicaid member
  - Include all claims associated to that particular Medicaid member in one complaint form.
  - Attach all supporting documentation—see checklist for examples—do not send medical records.
  - Every box on the complaint form has a purpose, please complete.
  - Identify the reason for the complaint, be as specific as possible, and attach any additional information which will be of assistance.
  - Submit complaint by mail or fax.
- Complaint received by MPPC
  - MPPC intake team member reviews complaint submission to ensure appropriate information is present, enters complaint into internal database, assigns a DOI file number and assigns the complaint to a team member responsible for that Medicaid region.
  - Team member reviews the complaint form and information submitted before opening the case for review and processing.
  - If any information is missing or if the complaint cannot be handled by MPPC, team member will notify the provider by mail, email or phone to explain.
  - Once ready to open, team member inputs the information from the complaint form into the internal database.
  - Team member sends an opening letter:
    - To the provider by mail or email acknowledging receipt of the complaint and identifying the DOI file number.
    - To the MCO by secure electronic submission and attaches all submitted documentation.
- MCO is given 15 calendar days to respond to complaint
- MPPC receives and reviews response from the MCO to determine next course of action
  - If the original MCO response completely resolves the complaint, then MPPC will input the MCO response into the internal database, complete closing transactions and sends closing letters to provider and MCO.
  - If the original MCO response does not clearly and completely resolve the complaint, MPPC sends the MCO response to the provider and requests the provider to respond within 15 calendar days.
  - When provider rebuttal response is received, the provider's response is sent to the MCO for review and response, normally the MCO is given seven days to respond.
  - Process is repeated as necessary or MPPC will initiate phone calls between MPPC and the MCO or with the provider until a resolution is determined.
  - If provider is to receive any monetary payment for claims, MPPC requires verification of transmittal of funds.
  - Once a resolution is determined, MPPC will complete closing transactions and send closing letters to the provider and MCO.

### **Checklist for filing a complaint:**

- ☐ Completed complaint form per Medicaid member per billing provider. When submitting a complaint for multiple claims and/or additional dates of service on the same Medicaid member, make sure you complete a separate **DESCRIPTION OF CLAIM AND VERIFICATION OF UNTIMELY PAYMENT** for each claim number.
  
- ☐ Copy of all billing instruments (CMS 1500, UB-04 or ADA Dental) used per claim filed including all corrected claims.
  
- ☐ Identification of original or corrected claims filed including the claim numbers.
  
- ☐ Copy of any and all supporting documentation associated to the claim(s) being disputed:
  - Denial letters
  - Explanation of Benefits/payments
  - Prior authorizations
  - Recoupment requests
  - E-mails and telephone notes
  - Appeal requests and determinations
  - Other supporting documentation to assist in the review of the complaint

**Please try to place all submitted documentation in chronological order as associated to the claims in dispute.**

### **Please do not send medical records.**

After submission, you will receive a written notice that your complaint has been received. The MPPC team member assigned to your case may contact you if she/he has additional questions. Therefore, it is very important that you complete the complaint form and provide the requested information. Your complaint will be forwarded to the MCO for review and response. Both parties will receive copies of all correspondence.

## Complaint Form Sample

Provider Name:  ① NPI #:  ②  
Provider Specialty:  ③  
Provider's Place of Service Address:  ④  
City:  St:  ZIP:   
Provider's Contact Person's Name:  ⑤  
Contact Person's Company:  ⑥  
Mailing Address:  ⑦  
City:  St:  ZIP:   
Phone:  ⑧ Fax:  Email:   
*On behalf of the provider, I certify that the information is correct:*  
Name:  ⑨ Title:  Date:   
Managed Care Organization (MCO) Name:  ⑩  
Were you a participating provider with this MCO on the dates of service? ☐ Yes ☐ No ⑪  
Medicaid Member's Name:  ⑫ Medicaid Member ID #:  ⑬  
Page 1 of  ⑭

Claim#:  ⑮ Disputed Service Line(s):  ⑯  
Date services rendered:  ⑰ Date claim first sent to MCO:  ⑱  
Sent by: ☐ Mail ☐ Electronic Attach copy of original billing instrument (CMS 1500—UB-04) and EOBs ⑲

⑳  
Reason(s) for complaint:  
(Limit 1000 characters)

Has the Managed Care Organization (MCO): ㉑  
Acknowledged receipt of the claim? ☐ Yes ☐ No If yes, when?

Denied receipt of the claim? ☐ Yes ☐ No  
Made any payment? ☐ Yes ☐ No If yes, how much and when?

Recouped any amount on this claim? ☐ Yes ☐ No If yes, how much & when?

Denied the claim in writing? ☐ Yes ☐ No If yes, how much & when?

Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim? ☐ Yes ☐ No

If yes, when?  Has there been a determination? ☐ Yes ☐ No (Attach copy)

Has a state fair (administrative) hearing been filed on this claim? ☐ Yes ☐ No

Provider Name:  ㉒ Member Name:  ㉓ Page  of  ㉔

## Complaint Form Instructions and Tips

- |  |  |
|--|--|
| ① Provider Name  | Enter the <b>billing</b> provider's name as it appears in box 33 on the CMS 1500 form or box 1 on the UB-04 or box 48 on the ADA Dental form.  |
| ② NPI #  | Enter the <b>billing</b> provider's NPI number as listed with the billing provider's name above.   |
| ③ Provider Specialty   | List the provider specialty as listed with the Department for Medicaid Services and associated with the NPI number listed above.   |
| ④ Provider's Place of Service Address                                      | List the physical address of the billing provider's service location.  |
| ⑤ Provider's Contact Person's Name   | List the name of the contact person for communication regarding this complaint.  |
| ⑥ Contact Person's Company   | List the company name of the contact person, i.e. if you use a billing service and they are the contact for this complaint, list their name.   |
| ⑦ Mailing Address  | List the mailing address for the contact person.   |
| ⑧ Phone – Fax – Email  | Complete for the contact person.   |
| ⑨ Name   | Type or sign the name of the person certifying the submitted information is correct.   |
| ⑩ Managed Care Organization (MCO) Name                                     | Identify the MCO the complaint is being filed against.   |
| ⑪ Were you a participating provider with this MCO on the dates of service? | Indicate whether you were a participating provider with the MCO you are complaining about on the dates of service in the complaint.  |
| ⑫ Medicaid Member's Name   | List the Medicaid member's name as it appears on the billing instrument.<br><b>Only one Medicaid member per complaint form.</b>  |
| ⑬ Medicaid Member ID #   | List the Kentucky Medicaid ID number for this member, not the MCO ID number.   |
| ⑭ Page 1 of ____   | Identify the total number of pages included for this complaint form.   |
| ⑮ Claim #  | Identify the claim number related to your complaint. If you don't have a claim number, was this claim rejected on the front end by the MCO for incorrect information or other reasons? If so, please indicate this information in the "Reason(s) for complaint." |
| ⑯ Disputed Service Line(s)   | Identify the service lines from the billing instrument related to your complaint ( <i>i.e.</i> 1,2,4, 6). This helps identify which lines of services are in dispute.  |
| ⑰ Date Services Rendered   | Identify the dates of service for the claim in dispute.  |
| ⑱ Date Claim First Sent to MCO   | Identify the date you first filed this claim with the MCO.   |
| ⑲ Sent by: Mail    Electronic  | Identify how you submitted the claim to the MCO.   |
| ⑳ Reason(s) for Complaint  | Identify the reason(s) for your complaint for this claim number. Try to be as specific as possible. If needed, attach a more detailed description as an attachment and note in this box as, "See Attached."  |
| ㉑ Has the MCO  | These are a set of nine questions that need to be completed in full including dates and amounts if applicable.   |
| ㉒ Provider Name  | Identify the billing provider's name as listed in box 1.   |
| ㉓ Member Name  | List the Medicaid member's name as listed in box 12.   |
| ㉔ Page ____ of ____  | List the current page number of the total number of pages.   |



## Questions/Notes

## CONTACT INFORMATION

ADDRESS: Medicaid Prompt Payment Compliance  
Kentucky Department of Insurance  
909 Leawood Drive  
P.O. Box 517  
Frankfort, Kentucky 40602

PHONE: 502-564-6106  
TOLL FREE: (in KY) 800-595-6053 – Option 5  
FAX: 502-564-2555 Fax

EMAIL: [DOI.MCOCompliance@ky.gov](mailto:DOI.MCOCompliance@ky.gov)

WEBSITE: <http://insurance.ky.gov>  
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Medicaid Prompt Payment Compliance Branch